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SOME LESS KNOWN CLINICAL MANIFESTATIONS OF FILARIASIS—*Contd.*

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D.—SIMULATING THE DISEASES OF THE AUTONOMIC NERVOUS SYSTEM.

1. The following case is of interest in that it manifested a close resemblence to that extremely rare disease *Erythromelalgia* (Weir Mitchell's Disease).

An engine driver aged about 37 years began to feel burning pains in the feet with swelling. Subsequently he began to notice the limb congested and warm. The condition was very severe while in the engine and also while off duty towards evenings on warm days. He began to feel weak, tremulous, and suffered from other distressing symptoms of cardiac excitability. While he sought relief the upper limbs were also getting affected—this being rare, though possible, in Erythromelalgia. He had also dilated veins and throbbing arteries. The oedema was not of the "*Soft*" type. There was no evidence of any other disfunction of the autonomic nervous system. There was no evidence of adenitis. There was slight rise of temperature towards the evenings, but two days of recumbancy in bed brought the temperature to normal.

Tests usually applied for the integrity of the sympathetic nervous system including Brown's Vaso-Motor Index revealed a satisfactory state of affairs. The night blood, (and even the day blood), showed microfilaria in

abundance. Under customary remedies the disease was well under control. The person is working to this day.

2. THROMBO-PHLEBITIS MIGRANS.—Man aged about 40 years, clerk in a Government office—admitted for migrating phlebitis and high temperature, which ran an irregular course before it settled down. The migrating phlebitis was confined to the left upper arm, left side of the chest, and left suprascapular region. As the anatomical correlation of the venous drainage of these three zones is possible the term "migrating" is perhaps inaccurate. The patient complained in addition of pain over the precardia. As the patient was of an extremely nervous type and as he also had phlebitis of the superficial veins of this area, it was not possible to assert the possibility of inflammation of the deep seated veins. The agglutination reactions of the blood, for the enteric group of organisms, undertaken during the attack and subsequently upto six weeks, were negative. The night blood showed microfilaria. A suggestion was made as to the possibility of the cephalic vein being blocked by the adult worm. As the patient discontinued the treatment no further report is available.

3. Types simulating *Angioneurotic œdema* have already been discussed. While these notes have been in progress there have been a few more cases with fugitive swellings of the various parts of the body (terminal segmental swellings of the limbs are not reckoned here).

E.—PULMONARY TYPE.

As only one or two cases simulating asthma and chronic bronchitis were studied no great emphasis can be laid on this subject.

F.—RENAL EXCRETORY.

Cases of haematuria in association with microfilaria have been noted. Owing to the fact that one of these cases turned out to be one of Gravitz's Tumour (so called hypernephroma) during the process of investigation and as full investigations of the state of the kidneys were not possible in the other cases, an assertive diagnosis cannot be given.

G.—ABDOMINAL.

Cases simulating acute abdomen have been noted. But reference has already been available in the current medical literature. As the symptoms could easily be explained by the process of obstruction of the abdominal vessels or lymphatics and as it is the purpose of this paper to exclude the obstructive type no great emphasis is laid on this point.

H.—NEUROSIS.

The association of various grades of neurasthenia and subacute infections of filaria with few evident classical signs of filariasis is becoming increasingly common. Excepting those few cases of extremely nervous patients who refuse to dissociate the two terms filariasis and elepantiasis, many sufferers are beginning to realize the wisdom of knowing the truth and the desirability of early treatment if any such is possible. It behoves the family medical attendant to keep filariasis also in view while attempting to establish a diagnosis.

CONCLUSION.

The above observations under various headings are attempted if only to simulate the clinical study of this disease. Comments and advice are welcome.

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THE NEED FOR ASSOCIATIONS OF PHYSICIANS AND SURGEONS FOR INDIA

By

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In my lecture on "Post Graduate Medical education" (*Vide*-journal of South Indian Medicine, June 1937). I have indicated the urgent need for Colleges of physicians and surgeons on an All-India basis, if India is to be self-contained in point of post-graduate medical education. The modern scientific medicine has taken a firm root in the Indian soil and India is going to play a great part in the future development of the same. The several Universities and licensing bodies can take credit for producing a number of medical men and women, duly qualified to practise medicine. The University is a body with multifarious activities and has to deal with many faculties and innumerable examinations. So far as the higher degrees in medicine are concerned, the University can only give its titles after suitable examinations. But to expect the University to undertake every item of post-graduate medical education will be burdening it unnecessarily. Even if the University does take up this responsibility, it can only do so through men holding high places in the profession. It would indeed be much better, if the University is relieved of this burden to a certain extent. The profession itself should be the proper agent for creating and conducing an efficient system of post graduate medical education and research. Moreover India is a big sub-continent with several Universities and perhaps, in future, the number of universities will multiply by leaps and bounds. The India Medical Council will concern itself only with the graduate medical education and disciplinary control over the practitioners. Therefore there must be some independent agency which can bring together the physicians and surgeons of the whole of India, with the only object of enhancing the standards of medical and surgical practice and research. Such agencies exist in all the civilised countries and India should take its lessons from them all, but evolve a plan to suit its needs. Great Britain is a small country and even in that small country there are numerous corporations and associations. I am not concerned with the need

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for so many associations in a small country as it is a problem for British physicians and surgeons. We should study the systems in such big continents like America and Australasia where the federal system of Government is prevailing. Both America and Australia have got their own colleges of surgeons. The Australian one is a recent one and the American was started in the second decade of this century. In the course of this paper I shall naturally deal with the college of surgeons and the same arguments and considerations should hold good for college of physicians also. This would save endless repetitions.

The Twin Associations.

The medical and the surgical associations should, in my opinion, be separate, though they can mutually co-operate with each other, in many respects. Ocassionally on professional matters, joint sessions can be held though each should have an individuality of its own in point of administration.

Aims.

The aims must be high. The aim should be firstly association of surgeons by frequent contacts and exchange of ideas, secondly, efficient postgraduate education in surgery and evolution of high standards of surgical practice and thirdly surgical research. All these aims should eventuate in a self-reliant India in point of the highest standards of medical and surgical practice. In the recent past, attempts and proposals have been made to create Colleges of physicians and surgeons just to grant licences to practise medicine and surgery, in imitation of the licentiateship of the Royal College of Physicians and Surgeons of England, Scotland and Ireland. The Government diploma of the L. M. P. which is not recognised by the Indian Medical Council as well as the General Medical Council in England, is responsible for this wish. Where is the need for two standards for the qualifying diploma to practise medicine ? The insidious distinction between graduates and licentiates might have had a purpose in the 19th century when the Government had to employ different grades according to medical castes such as super-Brahmin, Brahmin and sub-Brahmin Medical Communities. Now, the majority of the qualified medical men and women are going to take independent practice and a good number may serve the state institutions in an honorary capacity. In modern medicine why should you have insidious distinctions ? Did Gray write two books on Anatomy to serve the purposes of graduates and licentiates ? The qualifying diploma should be one and one only. The standard for the Madras L. M. P. at any rate, is very nearly equal to the M. B. degree. With some

more improvements and adjustments, the standards are going to be identical. Moreover, a good number of men seeking admission into the Stanley Medical School are passed intermediates If, in future, admission to the school is to be restricted to the passed intermediates and men with higher qualifications, what is the use of this medical anachronism? Why not do away with the L. M P. and make the Stanley Medical School and other institutions training centres for the M. B. degree. It is essential that our degrees must be recognised by the Indian Medical Council. It is immaterial whether the General Medical Council recognises our degrees or not. So, if at all the associations of surgeons and physicians are started, they should not concern themselves with qualifying degrees or diplomas. Their only aim should be a high standard by post-graduate medical and surgical education, so that the physicians and surgeons, who are fellows of the association, may have the unqualified confidence of the public in their professional attainments.

Fellowships.

There need be only one diploma of Fellowship with which the associations may concern themselves. The surgical fellowship for instance, should be a pass-port for a high standard in the art and science of surgery. The examination or the test for fellowship should not slavishly follow the English or the American model which, according to themselves are fundamentally defective. The Australasian model is based on the experiences of the defects of the English and the American models. With suitable alterations to suit Indian conditions, the Australian model can be adopted.

Foundation Fellows.

The association should have a number of foundation fellows. On the date of inaugurating the fellowships, all the practising surgeons of India, who hold either a Master's degree in surgery of an Indian university or an university recognised by the association, or a Fellowship of a college of surgeons in the British Empire recognised by the association, can be made foundation fellows on payment of Rs. 200 to the association. Subsequent entrants must go through an examination, the scope and standard of which should be decided by the foundation fellows.

Annual meetings.

The association should meet annually at the different university or surgical centres. At those meetings there can be free exchange of ideas, methods, and discussions on current topics of professional interest.

Post-graduate Education.

Under the auspices of the association, different provincial centres can organise an efficient system of post-graduate education by frequent professional meetings and clinical demonstrations. Leading surgeons can take and train assistants and put them through the mill of surgical practice for at least five years before they are allowed to sit for the fellowship examination. During this apprenticeship of five years the candidates for fellowship should have intensive and extensive training in the art and science of surgery including surgical pathology and anatomy.

Research.

Research spirit and research instinct should be cultivated by all the members and fellows. Every-day clinical medicine and surgery should provide ample material even for high grade research. The most perfect machine ever created by God is the human machine, and the numerous diseases which the human machinery is subject to, are large scale experiments by nature. The pathogenesis of a given disease, its course and development, and the final annihilation of the human body, are masterly experiments of the Divine Nature and if our associations assiduously cultivate the research spirit, more can be learnt by clinical study and observation than by experiments in a test tube or on a laboratory animal. This does not necessarily mean that test-tube research or animal research should be tabooed but I mean, that greater recognition must be given to pure clinical research. The munificence of Lord Nuffield in endowing large sums in Oxford for clinical research, is an epoch-making step, and I hope, India may be able to produce several Nuffields and several Oxfords. Under the auspices of the Association different provincial centres should organize surgical museums. The Association should also finance men doing specific research work and should send suitable men to foreign centres of research for study.

Examinations for Fellowship.

As I have mentioned before, a title of fellowship, should be a public acknowledgement of the candidate's high proficiency in the art and science of surgery. Edward W. Archibald of Montreal in his presidential address of the meeting of the American Surgical Association on "High degrees in the profession of surgery." (*Vide* Annals of Surgery. Oct. 1935. P. 481) said as follows :—

" In these latter days, and perhaps particularly in this new and progressive continent, there has arisen in considerable numbers a certain type of

surgeon which we all recognize and deplore. He is the natural product of those discoveries and inventions—Anaesthesia, asepsis, fine tools, and well equipped small hospitals—which have rendered the practice of surgery, in its purely mechanical aspects, relatively safe. He is also the product of some of our national qualities, characteristic of all young and rapidly developing countries. He is progressive, venturesome, and self-confident, and such qualities are perhaps, those which have placed the best of American surgeons in their present proud position. But in the particular type to which I refer, venturesomeness becomes foolhardiness and self-confidence is uncontrolled by knowledge. To such a man the sum of acquired knowledge, is confused in the popular theories of the year just past. Theory is counted as fact, and hypothesis as a thing proved. A decision to operate is based upon a Medical catch-word, or a rule of thumb. Technique becomes the be-all and end-all of surgery. Fingers replace brains and handicraft outruns science. The result is that such a surgeon is apt to undertake operations which may be technically possible but are scientifically unjustified. It is, our medical friends infer, an attitude of mind, which is the product of half-baked knowledge, which, in the last analysis, has in it more than a touch of carelessness, indeed, often towards the internist, a touch of impertinence. The medical man, interested and anxious, who finally decides upon surgical consultations, is often more in fear of the slipping mind than of the slipping hand."

Speaking about the fellowship examinations in England Dr. Archibald says:—' To become a fellow of the Royal College of Surgeons of England, a candidate has first to produce evidence that he has been engaged in the study, or the practice and study of the profession for at least six years after graduation. The only other requirement is that he should pass the examinations, primary and final, set by the board of examiners of the College. That is recognized as an extremely arduous task. It demands of the average candidate special preparatory study of several months' duration, with usually the help of a coach or tutor, both for the primary examination in anatomy and physiology and for the final in surgery, surgical anatomy, cadaver operations and surgical pathology. One who passes these examinations and becomes a fellow of the college can be depended upon to possess a wide and and sound knowledge of these subjects. But it is a curious fact that apprenticeship experience in a hospital is not categorically demanded, and, therefore, the candidate's experience in the performing of operations may be decidedly limited. Even if, as a matter of fact, the majority of the candidates have served for several years as house surgeons, the degree itself guarantees no particular ability in the conduct of operations That, I think, is the chief defect in the English and Scotch admission to Fellowship, in so

far as the F. R. C. S. degree suggests to the public the possession of skill as well as of knowledge."

He quoted Doctor Martin who spoke of the standards "adopted and in use by the time-honoured colleges of surgeons of England, Ireland and Edinburgh". "It was found that almost without exception their requirements and tests were formulated before modern surgery came into existence* * * After thorough and careful study of the whole problem there was no reason why we should begin by adopting obsolete plans to a twentieth-century progress." The requirements for admission as fellows of the American College of Surgeons are (1) Graduation from an approved Medical College (2) One year's internship in a creditable hospital (3) "Five to eight years after guaduation in medicine, devoted to special training and to practice, is normally, the time requirement for eligibility to fellowship, so that the candidate may prove that he has the proper temperament, and is mentally and mechanically adapted to do surgery" (4) Moral and ethical fitness of the candidateshall bedetermined by reports of surgeons whose names are submitted by the candidate himself etc. "At this point the candidate's application, together with the replies from his "references" are referred to the State or Provincial Committee of credentials, which votes to accept, postpone or reject the applicant. If accepted, he is then required to file complete case records of 50 major operations performed by himself, and brief abstracts of 50 major operations at which he has acted as assistant, or performed himself. These records are then examined by a committee of surgeons in Chicago. This Central Committee, in the past seven years has had to read carefully from 59,000 up to 67,300 of such case records each year...."

"The Australasian College, having clearly in their minds the two systems of creating fellows as established in England and in America gradually formulated their own system which was designed to combine the advantages of both. Their fundamental principle was 'to superimpose upon a sound training in the principles of surgery, entailed in the acquisition of senior surgical degree or diploma, a period of apprenticeship to a senior surgeon in operative and clinical work'. Such requirements amounted in practice to demanding of a candidate that he has the same sort of primary examination as obtains for the fellowship of the Royal College of Surgeons of England; that is, a stiff examination in anatomy, physiology and pathology; and of demanding over and above this a sufficiently long experience (five years post-graduate training in surgery as a minimum) in the actual practice of surgery under an approved senior surgeon. This they considered to be much more desirable

than the submission of 50 or 100 case reports of operations actually done by the candidate, as in our American system."

So far as India is concerned, I would do away with the examinations in anatomy and physiology as the training and teaching in anatomy and physiology for the medical undergraduate is quite sufficient. I would have first the graduate to undergo (1) House physician's course 6 months (2) House surgeon's course 6 months (3) Midwifery and Gyneocology 6 months (4) Ophthalmology 3 months and (5) Oto-rhinolaryngology 3 months and then (6) Apprenticeship with an accredited surgeon for 5 years during which the candidate should make himself proficient in clinical and operative surgery, surgical pathology and anatomy. (7) Examination for fellowship. The examination should be written, clinical and oral. The oral examination should be mainly devoted to surgical pathology and anatomy. The examination fee may be Rupees Two hundred and the diploma fee for approved candidates another two hundred.

Centres of examinations.

Each University or surgical centre, which has a good surgical pathology museum, and other conveniences, may, by rotation be the centres of examination.

Examiners.

The examiners must be fellows of the association and should be elected for three years at the rate of one examiner for each university or surgical centre. Of the first set of examiners one-third should vacate at the end of the first year and one third at the end of two years and so on, so that there can be continuity of the standards. No examiner should be permitted to hold office as examiner for more than three terms of three years each.

Executive Committee.

There should be an executive committee of as many members as there are university or surgical units who should be elected annually by the provincial units. The president of the year must be a person who should be elected by the provincial unit, having the annual sessions at a particular centre. The secretary and treasurer should be appointed by the president of the year from among the members of the provincial unit. The president, secretary, treasurer, and other members of the committee should hold office for one year.

Membership of the Association.

There can be two classes of members. Ordinary members may pay an annual subscription of Rupees Ten and associate members, a subscription of Rupees five. The ordinary membership should be confined to those who practise Surgery in all its branches as a speciality. The associate membership should be open to any registered medical practitioner. Only ordinary members should have franchise to elect working committee members from among themselves.

Indian Journal of Surgery.

To start with, the journal may be a quarterly. It may be published from a place to be decided by the executive committee. Such a place may have the honour of having a central office of the association. The journal must be given away free to all the ordinary and associate members. Non-members may get the journal at a subscription to be decided by the committee.

Conclusion.

The medical profession in India, should shed the inferiority complex and go ahead with the inauguration of these associations At the time the All-India Medical Conference holds in annual sessions in Madras, in December this year, the associations can be started under good auspices.

EXTRACTS FROM THE MEMORANDUM FROM THE REPRESENTATIVES

OF

1. THE INDIAN MEDICAL ASSOCIATION, BOMBAY BRANCH,
2. THE MEDICAL ASSOCIATION, BOMBAY NORTH AND
3. THE BOMBAY OBSTETRICIAL AND GYNÆCOLOGICAL SOCIETY,

TO

THE HONORABLE MINISTER OF HEALTH, BOMBAY.

Re-Organisation and Extension of Medical Relief in Urban and Rural Areas.

(a) PRESENT CONDITIONS:

3. It is admitted on all hands that the medical aid available at present to the people of the Province is generally inadequate and badly organised. It is woefully so in the rural areas. There are several reasons for this state of affairs. The principal reason appears to be that the organisation of medical relief so far has been haphazard, no estimations of the need of the people in the matter have ever been made and consequently no long term plan to meet it has been evolved. Health of the people has never formed a serious concern of the established Government, and consequently no adequate funds were ever spared for the purpose. In spite of the smallness of funds allotted, an inordinately heavily paid foreign medical service has been maintained, even at a time when there is no dearth of highly trained medical men in the country. And we regret to have to say that the very medical well-being of the people has been sacrificed to the welfare of this foreign medical service. We urge the present Government to review the subject in its entirety and evolve a suitable long term plan of action. A comprehensive survey of the situation will be necessary to indicate clearly what is required. Clear principles for action will also have to be enunciated so that no mutually contradictory policies are followed and funds and energies dissipated.

4. In the meanwhile we venture to suggest some points for immediate consideration and action.

(*a*) Progressive re-organisation of medical relief on the basis of *local effort* and under *local control*, with suitable financial aid from Government and

(*b*) Re-organisation of the medical services of the Province, iucluding the complete abolition of the civil side of the Indian Medical Service.

We recommend that medical relief, in contra-distinction to public health work, should be largely organised on the basis of *local effort* and under *local control*. With the present resources of Government we do not see a possibility of any great extension of rural medical relief unless local fervour and patriotism are harnessed for the purpose.

(b) DISTRICT HOSPITAL AND DISPENSARIES.

5. The first point to consider then, is, should the existing organisation of civil hospitals and dispensaries in different parts of the Province under Government management continue as hitherto ? We are strongly of opinion that so long as Government continue to be in charge of these institutions, there will not be much scope for expansion until a considerable improvement in the finances of the Province sets in. But if these institutions are handed over to the municipalities and local boards for management and control, there is every possibility of their expansion. The growth of the Vadilal Sarabhai General Hospital at Ahmedabad is a case in point. Local patriotism and resources are more likely to be available for the development of the civil hospitals, if they are handed over to the local bodies.

6. Government should however continue to make grants equal to the sum they are at present spending on hospitals and dispensaries. The municipalities or the local boards concerned would be held responsible for the cost (non-recurring as well as recurring) of their maintenance and of their expansion in future. A committee of the municipality or local board would also be held responsible for the management of the institution, as is the case with the Vadilal Sarabhai General Hospital at Ahmedabad, or with County Hospitals in England. With the rapid growth in the number of highly qualified and well experienced medical practitioners in the Province, which has taken place during the course of the last five years, it should not be difficult to find a sufficient number of such practitioners willing to settle down in district and other important towns in the Province, if such a policy is adopted. But as long as a Civil Surgeon is in charge of a hospital and so long as he also competes with the independent medical practitioners in private practice, it is not possible to attract highly qualified and experienced men to settle down in district and other towns to any appreciable extent. The advantage of the policy herein recommended would be, that each district hospital would be able to have a number of specialists attached to it, *viz*

one or more Physicians, Surgeons, Ophthalmic Surgeons, Aural Surgeons, Obstetricians and Gynæcologists and also Skin and Venereal Specialists and Dental Surgeons. It would be also possible to attract a Radiologist to the place, if the district town happens to be a large and prosperous city. This arrangement would bring more skilled medical and surgical aid to the villagers round about the district and other important towns. The inhabitants of these areas would be saved thereby the worry and expense of going to such large cities as Bombay, Ahmedabad and Poona, as they are compelled to do at present on account of the paucity of skilled medical assistance nearer home. This would also relieve the congestion of patients in the City hospitals, which is tremendous at present. The cost to Government so far as medical relief in cities and large towns is concerned would be kept at its present level, and any fresh funds available could be entirely used for rural areas.

(c) VILLAGE MEDICAL RELIEF:

7. As regards the rural areas, the present number of dispensaries will have to be increased, but again on the basis of local effort, and with Government aid. Medical practitioners should also be encouraged to settle in the villages in large numbers by giving them a better subsidy than at present. Also the device of mobile dispensaries for special diseases must be considered and exploited. Steps will have also to be taken to train a large number of health visitors for villages, and the nursing arrangements should be made available for the rural areas.

(d) POSSIBLE RESULTS OF OUR RECOMMENDATION.

8. The ultimate result of following these suggestions would be that Civil Surgeons would disappear from most of the district towns in course of time. It is not proposed that all of them should be abolished forthwith, nor is it likely that every municipality or local board would jump at the offer implied in these recommendations. It would certainly mean that as these ideas spread and are taken up, further recruitment in the Bombay Medical Service would cease. In case, a large number of local bodies are attracted to these proposals it may even be necessary to retire some of the Civil Surgeons on proportionate pension or to absorb them in the school medical service to be established under the Public Health Department. It is no doubt true that a number of Honorary Medical Officers have been appointed in some of the district hospitals. But so long as the present system of control which hampers individual initiative and endeavour is not done away

with, and so long as civil surgeons are in complete charge of hospitals and also covetous of private practice, it is not possible to attract highly qualified and well experienced honorary staff to these posts in the district hospitals.

(e) ABOLITION OF FREE MEDICAL TREATMENT TO GOVERNMENT SERVANTS.

9. Another outcome of this change of policy would be that the free medical treatment which well paid Government servants receive at present will have to be stopped. It is high time that this happened. District hospitals and local dispensaries are in a way charitable institutions, to be resorted to by the poor and we see no reason why officers in receipt of good salaries should either receive treatment at these hospitals, or receive free visits from medical officers attached to these institutions especially when they will be honorary or part time workers. When medical practitioners were few and far between in this country, one could understand the wisdom of arranging for the medical treatment of those employed in Government service. But with the presence now of qualified and registered medical practitioners even in small towns, with populations of about 5,000 or so, it should not be necessary for Government to provide special facilities for the treatment of their officers and other well-paid employees. We are aware of the fact that the rules of the covenanted services provide for free medical treatment for the members of these highly paid services and it might seem anomalous if the relatively poorly paid Indian officers were denied such a privilege, while the highly paid covenanted officers continued to enjoy it free of any appreciable cost. There are unfortunately a large number of anomalies in the Government of this country, and it should be the function of a popular Government to remove them as far as possible and the Secretary of State for India should be requested to modify the rules regarding free treatment, so far as the future recruitment to these services is concerned.

* * *

APPOINTMENT OF SENIOR AND JUNIOR SPECIALISTS.

The appointment of British officers as senior and junior specialists in the major teaching institutions of the country is the strangest of all these provisions. In the Army, Indian medical officers are appointed as specialist officers, and their services are regularly utilised for the care of the British sick. Further, British officers in civil services constantly consult Indian (non-official) consultants of their own free choice, as they are often the best and most highly qualified professional men in the country. It is therefore difficult to comprehend the creation of these specialist posts for British

medical officers of the I. M. S. Obviously, it is not due to any lack of specialists, nor is the provision made with any view to help the teaching institutions, as there are already plenty of highly trained physicians and surgeons in the country to man the teaching institutions ably. On the contrary, it is obvious that the appointment of British I. M. S. officers as senior and junior specialists in the major teaching institutions will subordinate the interests of medical education to those of the British members of the Indian Medical Service. These officers will be mostly inexperienced when drafted as junior specialists, and will have to take time to acquire skill and experience.

THE ENTIRE ABOLITION OF THE CIVIL SIDE OF THE I. M. S. STRONGLY URGED.

The spirit, which dominated the British members of the I M. S in 1914, unhappily still actuates them, both in their insistance on the 'Chief attractions' of the Service, and in their dealings with the medical profession in India The service members after retirement to England also have not hesitated to use the influence which the British Medical Association has with the British Government against the independent medical profession in this country This they will continue to do, so long as there is money to be made in India by their employment as Civil Surgeons or as Specialists. Our request, therefore, is that the Congress Ministry in Bombay, in association with the other Provincial Governments, should fight for the entire abolition of the civil side of the Indian Medical Service, which was even recommended by the Services Sub-Committee of the 2nd Round Table Conference in 1932, and bring about a wholesale re-organisation in the cadre and salaries of the medical staff to be employed in the Public Health and Medical Relief organisation of the Province. While the Province may retain all those Indian Medical Service officers who were in permanent civil employ prior to 1935, those of them who have been posted to the civil side in the last two years, whether British or Indian, should be immediately sent back to the military under the existing rules to that effect. The Indian Medical Service should be continued henceforth as a purely military service. Even on the military side, no discrimination should be permitted in the system of recruitment of British and Indian officers, and the recruitment should be exclusively by the method of open competitive examination to be held in India only. The country cannot possibly accept the arrangements laid down in Government of India Resolution No. 205 of 25—3—1937 regarding the organisation of this Service. All Local Governments must strenuously oppose the underlying principle of the said resolution and seek to make it void.

JOURNAL OF SOUTH INDIAN MEDICINE

SEPTEMBER, 1937

REORGANIZATION OF MEDICAL RELIEF.

Readers of this journal are aware of the repeated attempts made by us in these pages to draw the attention of the Government and the public to the defects in the organization of medical relief in this Province particularly and in the country in general. The Local Government have from time to time rectified some of the defects. But the efforts have been spasmodic and without plan. For, the Government till now had to work within the severe limitations of rules and regulations which were devised long ago and which had ceased to have any bearing on the needs of the present.

With the new order of things in this country, the Local Governments have many powers to order their affairs with greater attention to current needs. The public have suffered long, painfully conscious of the futility of their representations and protests. They have again come forward to press their requirements on the attention of the Government. The Ministers in charge of the Public Health Portfolio in different provinces have themselves come forward with their reading of the situation, and have expressed their desire to do the proper thing by the public. And it is more than fortunate that at this time, the public Health Portfolio is in the hands of experienced medical men who have for long been helpless witnesses to the unfair and wasteful methods of medical relief.

Individuals and public bodies come forward with their suggestions and remedies. They are in a hurry to set things right. And some of the suggestions are conflicting. Long brought up in the evil tradition of group and class interests, it seems to be difficult for some medical men to realize that the profession as a whole has only one interest, whatever imaginary groups the individuals might belong to. And that interest is its duty to relieve the suffering of the sick and to help prevent devastating illness in the country. We do not ignore the interests of the profession and the individual. But on a close examination it will be found that this is intimately bound with the former. For, to achieve the purpose

of rendering useful service to the sick public and bringing about hygienic surroundings the profession itself must be properly looked after by the state or the public

It is an undoubted fact that qualified medical men are not easily available in vast areas of this country. At the same time a large number of qualified men are idle for want of sufficient work. The demand for doctors is great. The supply of medical men, though not adequate, is still available. But unfortunately the demand and supply do not reach other. The urgent problem therefore is to bring about a re-orientation of policy whereby the available medical men could be more fully utilized to enlarge medical relief. To make a few more appointments of Honorary Medical Officers, to fix a tenure for these appointments, the abolition of a few paid posts, the opening of a few more Rural Dispensaries. or rebuilding of old headquarters hospitals, all these by themselves will be of little avail. It will be mere tinkering with the problem of better medical relief.

When medical men realize that their interests and duties are identical, they would come together much more easily and their considered suggestions for the improvement of the deplorable situation would be much more useful. We therefore welcome the memorandum which has been submitted to the Minister for Public Health of Bombay. This Memorandum has been prepared after joint deliberation of the repersentatives of the various Medical Associations of Bombay. We draw the attention of our readers to the extracts which we publish in this issue from the above Memorandum. It deals with certain conditions which are common to all provinces and also to certain affairs which are chiefly of local interest in the Province of Bombay.

We would appeal to the members of the profession in this Province who are members of various Medical Associations to use their influence to persuade representatives of the different associations to come together to take stock of the existing situation in matters of Medical relief and education and to suggest means to rectify the defects and to enlarge the scope of medical relief.

DOCTORS AND DRESS

Ever since Eve decided to eat the forbidden apple, wearing apparels have been always the problem of human races. To add to their troubles. sophistry and society have been setting increasingly difficult conventional standards. But it looks as though the twentieth century is going to see the release from these conventions or even revolt against it. Everywhere one sees lesser and lesser parts of anatomy covered—Eve of course taking the lead once again. Then, there is the happy example set by the nudists. One admits that they are segregated away from the view of society. Yet their doings are watched with interest, their journals oversubscribed and their activities are held to be achievements in certain quarters. Now and again Law has to and does inferfere. A few days ago a maiden of becoming appearance indulged in total nudity while out bathing in public. She was apprehended by Law. Though acquitted under First Offenders' Act, she came in for some trenchant remarks from the magistrate, as the law of the place demanded some clothes to be worn. Her over-powering urge to be nude expressed itself by her donning some transparent clothes and thus helped her to evade the Law. Somebody forgot to say decent clothes! Yet that is how the wind blows.

'Brevity is the Soul of wit" is not always true especially when it concerns the wearing apparel. Dress is a much more serious matter especially with certain avocations—for example the Doctor, the Soldier, or even the Policeman. The patients, desire to associate their favourite medical attendant with a certain type of garb. They seem almost distressed if the doctor chooses to alter it radically. The make-up seems to help the doctor towards the establishment of mental communion with the patient—the mixture or the pill acts better—. Anyway the patient is saved the first mental 'Jar-r-r'. It is perhaps the same psychology that helps the army to move. Visualize a commandant turning up in pyjamas to shout in a full throated voice "QUICK MARCH". Alas! there shall be no quick marching—. The individual in the soldier starts arguing within—. "Why the Dickens should I march? Surely I am sane enough to refuse to be fodder for the enemy's cannon". The same commandant dressed up with all the badges, medals, and stripes, like the decorations of a Christmas Tree, has no difficulty whatsoever in persuading his troops to undertake the same insane move.

Any decent dress is good dress cannot be said for the followers of Aesculapius—distinctive rather than uniform, subdued rather than loud, comfortable rather than decorative is considered to be the objective—Yet so little realized, over-dressed to the point of discomfort, meticulous to the point of being self-conscious and clinging to the conventions that have long ceased to worry other avocations, the doctor is a sorry spectacle in the eyes of the sane and progressive world. Yet, the patient won't have him in any other way. In our own little home-town, calling to mind the faces that are gone but not forgotten, and the mode of dress worn, who can fail to recall the beaming Koman with a loose silk suit, a gold watch and a lace turban, Rangachari in a black alpaka coat and spotless white trousers buttoned rather low below the navel (still imitated where the skill cannot be copied) and Niblock in his economical pepper and salt suit that evoked a wag once to compose a verse that ran thus:

"Pepper and salt clothes I wear
For good and diverse reasons
For then my tailors' bills are rare
They last me through two seasons"

GLEANINGS FROM MEDICAL LITERATURE

20. CHRONIC SINUSITIS, ITS TREATMENT BY RADIOTHERAPY.

W. ANANDALE TROUP.

The Medical Press and Circular, 19-5-37, 482.

The author draws attention to the great number of cases who have undergone repeated operation and present themselves for treatment by radiotherapy and argues the adoption of a more conservative attitude in the treatment of this condition and a close cooperation between the Laryngologist and Radiotherapeutist.

It is pointed out that radiotherapeutic methods can only have a palliative effect if anatomical irregularities, deflected septum, grossly infected tonsils, are surgically dealt with prior to treatment being instituted. On the other hand surgical methods which remove healthy tissue as well as unhealthy mucous membrane with attached cilia, thus removing without any hope of substituting, nature's first line of defence is deplored.

The type of case which yields the most satisfactory results is the one where neither nasal obstruction nor ethmoidal polypi are present and tonsils are not grossly infected. The infective type yields more readily than the allergic type and the allergic type on top of an infective process less readily than a pure allergic sinusitis.

The treatment aims at decongestion of the ostia, purification of the blood supply to the sinuses and their mucous membranes, the emptying of the sinuses of the purulent matter, restoration of function of the mucous membrane and cilia and the protective function of the mucus, increased local resistance, restoration of the function of the macrophages, increased general vitality, elimination of secondary toxic manifestations and psychological treatment in cases threatened with nervous breakdown.

As *adjuvants* to treatment nasal douches are best avoided. Small carefully regulated doses of autogenous vaccine may be beneficial. Collosal manganese orally or parenterally, intestinal lavage, a good nourishing diet and a good preparation of Vitamin B have beneficial effects.

M. K.

21. REGIONAL ENTERITIS.

ARNOLD S. JACKSON,

Surgery, Gynaecology and Obstetrics, July 1937, P1.

Regional Enteritis, like mesenteric lymphadenitis is probably due to a low grade infection of the lymphatic system. Its etiology is unknown and it is quite distinct from the 'benign granualomas' described in medical literature. The previous conception of the disease as occuring in only the ileum is incorrect since it may be found not only in other parts of the small bowel but in the large intestine as well. For this reason the name "regional enteritis" is more appropriate.

Symptoms depend upon the stage, the location and the severity of the disease. Crohn grouped the cases into 4 clinical types representing progressive stages.

Group I. Simulating *acute intra-abdominal inflammation,* appendicitis in particular Pain and tenderness in the right lower quadrant accompanied by cramps, fever and leucocytosis with or without a palpable mass. At operation a greatly thickened and reddened terminal ileum which has a tendency to bleed. Mesentery oedematous with enlarged hyperplastic glands. Appendix may be involved by contiguity but shows no mucosal inflammation.

Group II. Symptoms suggestive of *ulcerative colitis,* diarrhoea and cramp like abdominal pains with occasional passage of blood and mucus in the stool. Severe anaemia may develop with marked weight loss, malaise and slight fever.

Group III. *Stenotic stage* as a result of extreme thickening of the wall most marked in the region of the ilocaecal valve. Symptoms of partial obstruction. Palpable mass, violent cramps and occassional vomiting and constipation.

Group IV. Formation of multiple fistulae.

Symptoms depend somewhat on the location of the lesion. The higher the constriction the more pronounced the symptoms of intestinal obstruction.

Diagnosis depends on the Rontgenologist. As the chronic stenotic form develops a filling defect of the terminal ileum with a mild ileal stasis

and distension proximal to the defect. The characteristic ' string sign ' due to the lumen showing merely as a fine line of barium is typical.

Differential diagnosis.—Conditions to be considered are acute appendicitis, mesenteric lymphadenitis, ileocaecal tuberculosis, intestinal obstruction, ulceritive colitis neoplasm and actinomycosis.

Pathology.—The involved section of the bowel together with its mesentery are greatly thickened and doughy like a " Soggy hose ". The regional lymphatic glands are enlarged.

Treatment.—Must be governed by the progress of the disease and the condition of the patient. Many acute cases do occur in which spontaneous recovery results. The resemblance to appendicitis is to close that appendictomy has frequently been performed without relief of symptoms.

In uncomplicated cases a one stage resection and multiple stage operations where abscesses and fistulae exist have been advocated. On the other hand the advisibility of subjecting rather poor surgical risks to the hazards of resections of considerable potions of the small and large intestine has to be borne in mind. In these an ileocolostomy would be appropriate and a subsequent resection if need be.

M. K.

22. CONGENITAL HYPERTROPHIC PYLORIC STENOSIS IN INFANTS.

EDWARD J. DONOVAN,

The Journal of the American Medical Association, 21-8-1937, Pp 558 et seq.

The condition is seven times more common in boys than in girls. The cause of the condition has not been definitely determined but developmental hyperplasia of the circular muscle of the pyloric ring appears to be the most plausible explanation. The results of various forms of medical treatment such as administration of atropine thick feeding or refeeding after vomiting are all unsatisfactory. Why the tumour disappears after the age of 3 months has not been determined.

The condition is completely and permanently cured by a section of the circular muscle as in the Fredt-Ramstedt operation which should be done in every case as soon as a diagnosis is established except in the case of a few infants, with mild symptoms and nearly 3 months old.

Symptoms.—Symptoms usually start about 3 weeks after birth and consist of vomiting which is projectile. The vomit never contains bile. Visible peristalsis is noticed after feeding, a tumour can in all cases be felt above and to the right of the umbilicus. The child is dehydrated and emaciated as the disease progresses.

Treatment.—Preperative preparation of the patient is of the first importance and has been the chief factor in reducing the mortality of the operation and consists of transfusion of whole blood and hypodermoclyses with physiological saline.

The complication at operation to be most dreaded is accidental opening of the duodenum since the change to the thin duodenum from the thick pyloric tumour is somewhat abrupt.

Post operative care consists of prevention of heat loss and very gradual feeding up since these infants have a poor food tolerance as a result of the prolonged starvation.

M. K.

ASSOCIATION NOTES.

SOUTH INDIAN MEDICAL UNION.

A meeting of the Council of the Union was held on Monday the 13th September 1937 at 6-15 p m., at 32, Broadway, Madras.

The following members were present.

Dr. V. D. Nimbkar (Vice-President in the chair)
„ V. C. Sudarsanam.
„ M. Krishnamurthi.
„ G. Zachariah.
„ E. V. Srinivasan.
„ P. Govinda Rao.
„ T. Satakopan.
„ C. R. Krishnasami.

1. The following Practitioners were enrolled as members of the Union.

1. Dr. V. Samuel, L.M.P.,
2. „ K. Parthasarathy, M.B., B.S.,
3. „ N. Chandrasekharan, M.B., B.S.,
4. „ K. G. M. Bhandary, M.B , B S. (Bom.)
5. „ W. V. Narasimha Iyangar, M.B., B.S. (Bom.)
6. „ V. Enok, M.B., B.S. (Hong.) L.O., D.G.O. (Dub.)
7. „ S. Krishnamurthy Rao, M.B., B.S., } Salem.
8. „ S. Valeeswaran, M.B , B.S., L.O. } Salem.

2. Dr. M. Subramania Ayer, B.A., M.B. & C.M. was nominated as a Trustee to the Health Propaganda Board in place of Dr. U. Rama Rao resigned.

3. The Financial statement for the month of August 1937 was presented and approved.

4. A letter from Dr. E. V. Srinivasan with reference to a recent circular in the various hospitals of the city drawing the attention of the honorary officers and others to the G. O. about terminating their services for inefficiency was discussed. It was decided to protest against this circular.

The meeting was then adjourned.

* * *

Accordingly the following letter was sent to the Secretary, to Government in the Ministry of Public Health, Madras.

Sir,

I have the honour to state that the attention of the South Indian Medical Union has been drawn to the G. O. Ms. No. 2136 P. H. dated 25th August 1937.

The Union feels it its duty to express its disapproval of the above order and also the manner in which publicity was sought to be given to it by circulating it to the honorary medical officers in some of the City Hospitals and by putting it up on the notice boards of other hospitals.

I have the honour to be,
Sir,
Your most obedient servant,
(Sd) T. SATAKOPAN, *General Secretary.*

THE TINNEVELLY DISTRICT MEDICAL ASSOCIATION PALAMCOTTAH.

(Affiliated to the Indian Medical Association).

Reception to the Honourable Dr. T. S. S. Rajan, L. R. C. P. (Lond.), M. R. C. S. (Eng)., Minister-in-charge of Medicine and Public Health by the Tinnevelly District Medical Association.

The Tinnevelly District Medical Association gave a reception to the Hon'ble Dr. T. S. S. Rajan, L. R. C. P., (London)., M. R. C. S. (England)., Minister-in-charge of Medicine and Public Health with the Government of Madras, on Sunday the 8th August 1937, at 4-30 p.m. at the St. John's College, Palamcottah.

The function began with a Tea Party given by Lieut. Col., T. S. Shastry, I.M.S., the President of the Tinnevelly District Medical Association and about one hundred members of the Medical Profession including 76 members of the Association attended the meeting. Dr. K. Narayanaswami Iyer, L. M. & S., Civil Surgeon, Tuticorin, and many of the members of the Independent Medical Practitioners' Association of Tinnevelly also attended the function on invitation. Among the non-medicals the following gentlemen attended the meeting :—

Mr. V. Ramakrishna, I.C.S., Collector of Tinnevelly.

M. R. Ry. Rao Bahadur I. C. Iswaran Pillai Avl., and

Mr. Daniel Thomas, B.A., and the Commissioners of the two Municipalities of Tinnevelly & Palamcottah.

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During Tea, Lieut. Col., T. S. Shastry, I.M.S., took the Hon'ble Minister round and introduced every member to him.

Dr. L. Mahadevan, M.B.,B.S., (Madras)., D. O. M. S., (London), one of the members of the Association entertained the gathering with Music on "Gottuvadyam". Then Lieut. Col., T. S. Shastry, in a short speech welcomed the Hon'ble Dr. T. S. S. Rajan. In his speech he made mention about Dr. T. S. S. Rajan's abilities as a Medical Man and his services to the Country. He also gave a short sketch of his career from the time of his College Studies upto his becoming the Cabinet Minister-in charge of Medicine and Public Health.

Then the Hon'ble Minister Dr. T. S. S. Rajan, delivered his address. He mentioned that Surgery is the easiest thing to practice, if one knows that he is doing and what to do when he is encountered with difficulties. He laid emphasis on a clear knowledge of practical Anatomy, before one takes to Surgery. He again mentioned that Surgery is the cheapest thing to practice as the capital investment is not more than Rs. 1,000 to start with. He laid stress on the self-confidence of the person who practices Surgery, without which very little can be done. He said he has taken up the Cabinet Ministership with great reluctance because he liked Surgery much more, and that he would like to continue to do surgery as long as his hands can hold the scalpel steadily. But he said the call of the Country has got a greater claim, and so he had to respond to it. He referred to some of the common surgical ailments like strangulated hernia and appendicitis, which any man of proper medical training must be able to tackle successfully in any village, depending on boiling as the means of sterilisation.

Then Dr. T. N. Govinda Iyer, M. B. & C. M., proposed a hearty vote of thanks to the Hon'ble Dr. T. S S. Rajan, for his readiness in accepting the invitation of the Tinnevelly District Medical Association. He also thanked Colonel Shastry, I. M. S., for his kindness in organising this most enjoyable function and entertainment and also proposed a vote of thanks to all the members and other medical men and non-medical guests.

THE MEDICAL PRACTITIONERS' ASSOCIATION, NUZVID.

A monthly meeting of the above Association was held at Nuzvid on 29—8—'37 at 4 p. m., in Dr. Mrs. N. M. C. Seshagiri Rao's quarters with Dr. P. Anjaiah Naidu in the chair. After light refreshments and coffee offered by Mrs. Seshagiri Rao, the meeting commenced with reading of

minutes of the previous meetings by the Secretary Mr. N. Rama Rao. Mr. P. Anjaiah Naidu narrated about a case of high blood pressure in a male aged 53 with intermittent attacks of hæmaturia of a severe type. Two other cases mentioned by him were one of acute intestinal obstruction due to round worms and the other of a primipara in difficult labour who later on developed a peculiar œdema of the face with dysphagia of indefinite origin (Diphtheria ?) and died subsequently.

Mr. N. Rama Rao mentioned a case of Typhomalaria in a lady after delivery that started on the 11th day with a sub-involuted uterus and the course was much prolonged and protracted for about a month.

Mr. V. Anantbacharyulu gave out a case of quinine Idiosyncracy in a female manifested after 10 gr. intramuscularly and 4 gr. orally.

All the above cases were followed by a discussion in which all the members took active part along with many more case reports and the meeting came to a close by 7-30 p. m.

RAMNAD DISTRICT MEDICAL ASSOCIATION.

August, 1937.

The August meeting of the Ramnad District Medical Association held at the Schwartz High School, Ramnad on Saturday the 28th August, 1937 was a joint meeting of the Ramnad District and Madura Medical Associations.

The extraordinary general body meeting convened to consider the amendments to the rules of the Association took place before the joint meeting under the presidency of Captain B. Dayananda Rao, the President of the Association. Out of 18 members who were eligible to vote having no arrears of subscriptions, 12 attended the meeting.

All the amendments recommended were passed *nemcon* with a slight alteration in the second amendment and that was passed *nemcon* with an addition of " Provided that two of the quorum are from the President, Vice President, Secretary or Treasurer."

The guests were all entertained to tea by Captain B. Dayananda Rao.

The joint meeting then commenced. Dr G. Ramaiya, L. M. & S., of Madura was voted to the chair.

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The Secretaries of the two Associations read the minutes of the previous meetings and they were adopted.

The Secretary of the Ramnad District Medical Association read letters from Hon'ble Dr. T. S. S. Rajan, the Secretary of the Tinnevelly District Medical Association, and from Dr. H. S. Thomas, Madura and requested those present, to give their opinion regarding a combined meeting held at Tinnevelly, Madura & Ramnad Associations by the Tinnevelly Secretary.

Dr. T. S. Shetty presented the following for consideration at the meeting :—

> "The combined meeting of Ramnad District & Madura Medical Association request the Ministry to make all endeavours to abolish the L. M. P. Course and to have uniformity in Medical Education with one registerable qualification and to have special diplomas in special Medical Subjects."

The Chairman moved that this be circulated to the members of the Medical Associations of the three Districts Ramnad, Tinnevelly & Madura and opinion invited to be considered at the next combined meeting proposed to be held at Madura on the 23rd October, 1937.

Dr. T. S. Shetty then read a paper on "Tympanic membrane and its pathology."

The following cases were demonstrated by Captain B. Dayananda Rao, Superintendent, Government Headquarters Hospital, Ramnad :—

1. A case of Herpes zoster in an adult female.

2. A case of multiple fibroids of uterus in which complete hysterectomy was performed.

3. Sequestrum removed from left tibia in a case of osteomyelitis of a boy.

Case reports on Typhus were read by Mr. J. R. Moses of Ramnad Headquarters Hospital and Captain B. D. Rao elucidated on these case reports and remarked that Typhus was prevalent in the district.

The chairman in his concluding speech hoped that such combined meetings will hereafter be more and more successful and thanked the President and members of the Ramnad District Medical Association for their kind invitation and hospitality.

The secretary of the Ramnad District Medical Association asked the members of the association to send proposals, regarding circulation of any journals that is recommended to be got for the Association and also such other questions that have to be placed before the next meeting; at the same time it was pointed out that though efforts were made to start a Library for the Association it was found impracticable to work out the scheme on account of the fact that the members came from several distant parts of the district and only very few were in one town.

With the vote of thanks from the Secretaries of the two Associations, the meeting terminated after authorising the two secretaries to arrange for the meeting of Tinnevelly, Ramnad & Madura Associations on 23rd October, 1927 at Madura.

The proceedings came to a close with a sumptuous dinner the host being Captain B. Dayananda Rao.

There were 49 medical members present, 36 from Ramnad, 12 from Madura and 1 visitor.

RAMNAD DISTRICT MEDICAL ASSOCIATION.

Affiliated to the Indian Medical Association.

September, 1937.

The September meeting of the Ramnad District Medical Association was held on Saturday the 18th September, 1937 at the Lady Pentland Hospital for Women & Children, Kanadukathan.

The members were all entertained to tea by Dr. E. Ivatts of Kanadukathan.

In the absence of the President and the Vice President of the Association Dr. T. S. Shetty was elected to the chair. The Minutes of the previous meeting read by the secretary was adopted.

Dr. M. Nagaswami of Manamadura read a detailed paper on. "Meningitis-Tubercular with notes of his own illness of protracted fever later diagnosed and treated for Tubercular Meningitis". After the chairman's remarks on the subject, the meeting terminated with the vote of thanks from the secretary.